

General

Guideline Title

Female genital cutting.

Bibliographic Source(s)

Perron L, Senikas V, Burnett M, Davis V, Social Sexual Issues Committee, Ethics Committee. Female genital cutting. J Obstet Gynaecol Can. 2013 Nov;35(11):1028-45. [63 references] [PubMed](#)

Guideline Status

This is the current release of the guideline.

Recommendations

Major Recommendations

The quality of evidence (I-III) and classification of recommendations (A-E, L) are defined at the end of the "Major Recommendations."

Introduction

Summary Statements

1. Female genital cutting (FGC) is internationally recognized as a harmful practice and a violation of girls' and women's rights to life, physical integrity, and health. (II-3)
2. The immediate and long-term health risks and complications of FGC can be serious and life threatening. (II-3)
3. FGC continues to be practised in many countries, particularly in sub-Saharan Africa, Egypt, and Sudan. (II-3)
4. Global migration patterns have brought FGC to Europe, Australia, New Zealand, and North America, including Canada. (II-3)
5. Performing or assisting in FGC is a criminal offense in Canada. (III)
6. Reporting to appropriate child welfare protection services is mandatory when a child has recently been subjected to FGC or is at risk of being subjected to the procedure. (III)
7. There is concern that FGC continues to be perpetuated in receiving countries, mainly through the act of re-infibulation. (III)
8. There is a perception that the care of women with FGC is not optimal in receiving countries. (III)

Recommendations

1. Health care professionals must be careful not to stigmatize women who have undergone FGC. (III-A)
2. Requests for re-infibulation should be declined. (III-B)
3. Health care professionals should strengthen their understanding and knowledge of FGC and develop greater skills for the management of its complications and the provision of culturally competent care to adolescents and women who have undergone genital cutting. (III-A)

Clinical Management of Women Living with FGC

Summary Statement

9. FGC is not considered an indication for Caesarean section. (III)

Recommendations

4. Health care professionals should use their knowledge and influence to educate and counsel families against having FGC performed on their daughters and other family members. (III-A)
5. Health care professionals should advocate for the availability of and access to appropriate support and counselling services. (III-A)
6. Health care professionals should lend their voices to community-based initiatives seeking to promote the elimination of FGC. (III-A)
7. Health care professionals should use interactions with patients as opportunities to educate women and their families about FGC and other aspects of women's health and reproductive rights. (III-A)
8. Research into FGC should be undertaken to explore women's perceptions and experiences of accessing sexual and reproductive health care in Canada. (III-A) The perspectives, knowledge, and clinical practice of health care professionals with respect to FGC should also be studied. (III-A).
9. Information and guidance on FGC should be integrated into the curricula for nursing students, medical students, residents, midwifery students, and students of other health care professions. (III-A)

Providing Culturally Competent Care to Women and Adolescents with FGC

Recommendation

10. Key practices in providing optimal care to women with FGC include:
 - a. Determining how the woman refers to the practice of FGC and using this terminology throughout care. (III-C)
 - b. Determining the FGC status of the woman and clearly documenting this information in her medical file. (III-C)
 - c. Ensuring the availability of a well-trained, trusted, and neutral interpreter who can ensure confidentiality and who will not exert undue influence on the patient–physician interaction when providing care to a woman who faces language challenges. (III-C)
 - d. Ensuring the proper documentation of the woman's medical history in her file to minimize the need for repeated medical histories and/or examinations and to facilitate the sharing of information. (III-C)
 - e. Providing the woman with appropriate and well timed information, including information about her reproductive system and her sexual and reproductive health. (III-C)
 - f. Ensuring the woman's privacy and confidentiality by limiting attendants in the room to those who are part of the health care team. (III-C)
 - g. Providing woman-centred care focused on ensuring that the woman's views and wishes are solicited and respected, including a discussion of why some requests cannot be granted for legal or ethical reasons. (III-C)
 - h. Helping the woman to understand and navigate the health system, including access to preventative care practices. (III-C)
 - i. Using prenatal visits to prepare the woman and her family for delivery. (III-C)
 - j. When referring, ensuring that the services and/or practitioners who will be receiving the referral can provide culturally competent and sensitive care, paying special attention to concerns related to confidentiality and privacy. (III-C)

Definitions:

Quality of Evidence Assessment*

I: Evidence obtained from at least one properly randomized controlled trial

II-1: Evidence from well-designed controlled trials without randomization

II-2: Evidence from well-designed cohort (prospective or retrospective) or case–control studies, preferably from more than one centre or research group

II-3: Evidence obtained from comparisons between times or places with or without the intervention. Dramatic results in uncontrolled experiments (such as the results of treatment with penicillin in the 1940s) could also be included in this category

III: Opinions of respected authorities, based on clinical experience, descriptive studies, or reports of expert committees

*Adapted from The Evaluation of Evidence criteria described in the Canadian Task Force on Preventive Health Care.

Classification of Recommendations†

- A. There is good evidence to recommend the clinical preventive action
- B. There is fair evidence to recommend the clinical preventive action
- C. The existing evidence is conflicting and does not allow to make a recommendation for or against use of the clinical preventive action; however, other factors may influence decision-making
- D. There is fair evidence to recommend against the clinical preventive action
- E. There is good evidence to recommend against the clinical preventive action
- L. There is insufficient evidence (in quantity or quality) to make a recommendation; however, other factors may influence decision-making

†Adapted from the Classification of Recommendations criteria described in the Canadian Task Force on Preventive Health Care.

Clinical Algorithm(s)

None provided

Scope

Disease/Condition(s)

Female genital cutting (FGC)

Guideline Category

Counseling

Evaluation

Management

Prevention

Treatment

Clinical Specialty

Family Practice

Obstetrics and Gynecology

Pediatrics

Intended Users

Advanced Practice Nurses

Health Care Providers

Nurses

Physician Assistants

Guideline Objective(s)

To strengthen the national framework for care of adolescents and women affected by female genital cutting (FGC) in Canada by providing health care professionals with:

- Information intended to strengthen their knowledge and understanding of the practice
- Directions with regard to the legal issues related to the practice
- Clinical guidelines for the management of obstetric and gynaecological care, including FGC related complications
- Guidance on the provision of culturally competent care to adolescents and women with FGC

Target Population

Female adolescents and women affected by female genital cutting (FGC)

Interventions and Practices Considered

1. Strengthening health care professional's understanding and knowledge of female genital cutting (FGC)
2. Education and counsel of women and their families
3. Provision of appropriate support and counselling services
4. Promotion of the elimination of FGC
5. Integration of information and guidance on FGC into the curricula for nursing students, medical students, residents, midwifery students, and students of other health care professions
6. Determination of genital cutting status and clear documentation of this information
7. Ensuring availability of a well-trained, trusted, and neutral interpreter
8. Proper documentation of medical history
9. Provision of appropriate and well timed information
10. Ensuring privacy and confidentiality
11. Provision of woman-centred care
12. Prenatal visits

Major Outcomes Considered

- Incidence and prevalence of female genital cutting (FGC)
- Legal impacts of FGC
- Morbidity
- Effectiveness of care
- Effectiveness of culturally competent counseling and care

Methodology

Methods Used to Collect/Select the Evidence

Searches of Electronic Databases

Searches of Unpublished Data

Description of Methods Used to Collect/Select the Evidence

Published literature was retrieved through searches of PubMed, CINAHL, and The Cochrane Library in September 2010 using appropriate controlled vocabulary (e.g., Circumcision, Female) and keywords (e.g., female genital mutilation, clitoridectomy, infibulation). The guideline developers also searched Social Science Abstracts, Sociological Abstracts, Gender Studies Database, and ProQuest Dissertations and Theses in 2010 and 2011. There were no date or language restrictions. Searches were updated on a regular basis and incorporated in the guideline to December 2011. Grey (unpublished) literature was identified through searching the websites of health technology assessment and health technology-related agencies, clinical practice guideline collections, clinical trial registries, and national and international medical specialty societies.

Number of Source Documents

Not stated

Methods Used to Assess the Quality and Strength of the Evidence

Weighting According to a Rating Scheme (Scheme Given)

Rating Scheme for the Strength of the Evidence

Quality of Evidence Assessment*

I: Evidence obtained from at least one properly randomized controlled trial

II-1: Evidence from well-designed controlled trials without randomization

II-2: Evidence from well-designed cohort (prospective or retrospective) or case-control studies, preferably from more than one centre or research group

II-3: Evidence obtained from comparisons between times or places with or without the intervention. Dramatic results in uncontrolled experiments (such as the results of treatment with penicillin in the 1940s) could also be included in this category

III: Opinions of respected authorities, based on clinical experience, descriptive studies, or reports of expert committees

*Adapted from The Evaluation of Evidence criteria described in the Canadian Task Force on Preventive Health Care.

Methods Used to Analyze the Evidence

Systematic Review

Description of the Methods Used to Analyze the Evidence

The quality of evidence in this document was rated using the criteria described in the Report of the Canadian Task Force on Preventive Health Care (see the "Rating Scheme for the Strength of the Evidence" field).

Methods Used to Formulate the Recommendations

Expert Consensus

Description of Methods Used to Formulate the Recommendations

Not stated

Rating Scheme for the Strength of the Recommendations

Classification of Recommendations†

- A. There is good evidence to recommend the clinical preventive action
- B. There is fair evidence to recommend the clinical preventive action
- C. The existing evidence is conflicting and does not allow to make a recommendation for or against use of the clinical preventive action; however, other factors may influence decision-making
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†Adapted from the Classification of Recommendations criteria described in the Canadian Task Force on Preventive Health Care.

Cost Analysis

A formal cost analysis was not performed and published cost analyses were not reviewed.

Method of Guideline Validation

Internal Peer Review

Description of Method of Guideline Validation

This clinical practice guideline has been prepared by the Social Sexual Issues Committee and the Ethics Committee, and reviewed by the Clinical Practice Gynaecology Committee, the Canadian Paediatric and Adolescent Gynaecology and Obstetricians Committee, and the Family Physicians Advisory Committee, and approved by the Executive and Council of the Society of Obstetricians and Gynaecologists of Canada.

Evidence Supporting the Recommendations

Type of Evidence Supporting the Recommendations

The type of supporting evidence is identified and graded for each recommendation (see the "Major Recommendations" field).

Benefits/Harms of Implementing the Guideline Recommendations

Potential Benefits

Appropriate and culturally competent care of adolescents and women affected by female genital cutting (FGC)

Potential Harms

Not stated

Qualifying Statements

Qualifying Statements

Qualifying Statements

This document reflects emerging clinical and scientific advances on the date issued and is subject to change. The information should not be construed as dictating an exclusive course of treatment or procedure to be followed. Local institutions can dictate amendments to these opinions. They should be well documented if modified at the local level. None of these contents may be reproduced in any form without prior written permission of the Society of Obstetricians and Gynaecologists of Canada (SOGC).

Implementation of the Guideline

Description of Implementation Strategy

An implementation strategy was not provided.

Implementation Tools

Foreign Language Translations

For information about availability, see the *Availability of Companion Documents* and *Patient Resources* fields below.

Institute of Medicine (IOM) National Healthcare Quality Report Categories

IOM Care Need

Getting Better

Staying Healthy

IOM Domain

Effectiveness

Patient-centeredness

Identifying Information and Availability

Bibliographic Source(s)

Perron L, Senikas V, Burnett M, Davis V, Social Sexual Issues Committee, Ethics Committee. Female genital cutting. J Obstet Gynaecol Can. 2013 Nov;35(11):1028-45. [63 references] [PubMed](#)

Adaptation

Not applicable: The guideline was not adapted from another source.

Date Released

Guideline Developer(s)

Society of Obstetricians and Gynaecologists of Canada - Medical Specialty Society

Source(s) of Funding

Society of Obstetricians and Gynaecologists of Canada

Guideline Committee

- Social Sexual Issues Committee
- Ethics Committee

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Financial Disclosures/Conflicts of Interest

Disclosure statements have been received from all members of the committees.

Guideline Status

This is the current release of the guideline.

Guideline Availability

Electronic copies: Available from the [Society of Obstetricians and Gynaecologists of Canada Web site](#) . Also available in French from the [SOGC Web site](#) .

Print copies: Available from the Society of Obstetricians and Gynaecologists of Canada, La société des obstétriciens et gynécologues du Canada (SOGC) 780 promenade Echo Drive Ottawa, ON K1S 5R7 (Canada); Phone: 1-800-561-2416.

Availability of Companion Documents

Appendices 1 and 2 of the [original guideline document](#) contain sections of the Criminal Code of Canada and statements and policies provided by provincial medical bodies that address or could be used to address female genital cutting (FGC).

Patient Resources

None available

NGC Status

This NGC summary was completed by ECRI Institute on January 31, 2014. The information was verified by the guideline developer on March 17, 2014.

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